 Member's Name: _____

7th Regiment Member - Medical Evaluation

Participating in Drum Corps is truly a mentally and physically challenging activity. It is considered a Performing Sport; Marching Band's "Major League."
The Health Care Provider must review Health History form filled out by member, and complete and sign the Medical Evaluation and Physical Examination. Thank you.

Member's Name: _____ Birth Date: _____

Date of Exam (must be within the last 12 months): _____

PHYSICAL EXAM:

Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: _____/_____

General:	Normal (Y/N)	Describe Abnormal Finding(s):
Neurological-General		
HEENT		
Dental		
Heart		
Lungs		
Abdomen/GI		
Genitalia/Hernia		
Skin Issues		
Orthopedic:		
Neck		
Shoulders		
Arms/Hands		
Knees		
Feet/Ankles		

 Member's Name: _____

General:	Normal (Y/N)	Describe Abnormal Finding(s):
History of Scoliosis? Severity?		
Surgical History		

Screenings:

Vision- Significant history? Need for Corrective Lenses			
Hearing- any issues with sensorineural or conductive hearing loss?			
Hct/Hgb Level:		Date:	
TB High Risk Group?	____No ____ Yes	PPD Date Read/Results/ Treatment:	

Please provide copy of immunization record.

Chronic Disease Assessment:

Daily or as needed Medications:

_____

_____

Asthma: ___ No ____ Yes ___Intermittent ___Mild Persistent ___ Moderate

Persistent. ___Severe Persistent ___ Exercise Induced

Last attack/exacerbation: _____

Prescribed Treatment: _____

Allergies: ____ No _____Yes

Food:_____

Insects: _____. Drug Allergies:_____

Latex: _____ Unknown Source: _____

History of Anaphylaxis/Cause:_____ Is Epinephrine required:_____

Chronic Disease Assessment Continued:

Diabetes: _____No _____Yes Type:_____
Date of Diagnosis/ Age: _____
Treatment: _____

History of Seizures: _____No _____Yes
Type:_____ Date of Last: _____
Treatment_____

Other Chronic Diseases/Conditions including but not limited to Anxiety, Immunodeficiency, etc:

_____

_____

_____This individual has an emotional, behavioral or psychiatric condition which may affect his/her/their performance and/or participation in the Drum Corps. If checked, please explain:

_____

_____

_____

_____

This individual MAY participate fully in the Drum Corps Program: _____
This individual MAY NOT participate - if so please explain: _____

Signature of Health Care Provider Performing Assessment:

_____

MD/ DO/ APRN/ PA Date Signed

Printed or Stamped Provider's Name, Address and Phone Number:

_____

_____